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MEDICAL LAW—THE RIGHT TO REFUSE ANTIPSYCHOTIC DRUG TREATMENT: SUBSTANTIVE RIGHTS AND PROCEDURAL GUIDELINES IN MASSACHUSETTS—*Rogers v. Commissioner of the Mental Health Department*, 390 Mass. 489, 458 N.E.2d 308 (1983)

The right of the mentally ill to refuse antipsychotic drug treatment¹ has provoked endless debate between the medical and legal communities.² While common agreement exists that a competent patient has a right to participate in the treatment decisionmaking process,³ no agreement exists whether incompetent patients have that

1. Antipsychotic drugs are a psychotherapeutic agent within the category of psychotropic drugs and are used to treat psychoses. Baldessarini, *Drugs and Treatment of Psychiatric Disorders*, in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 391, (L. Goodman and A. Gilman eds. 6th ed. 1980). The parties in *Rogers* focused exclusively on antipsychotics such as Thorazine, Mellaril, Prolixin and Haldol. *Rogers v. Okin*, 634 F.2d 650, 653 n.1 (1st Cir. 1980).

Although such medication is useful in controlling various psychoses, it may also exacerbate psychotic symptoms, cause confusion, stupor or coma, or cause neuromuscular reactions resembling Parkinsons disease. The most serious consequence of modern day psychotropic drug use in mental hospitals is tardive dyskinesia. See Plotkin, *Invisible Manacles: Drugging Mentally Retarded People*, 31 STAN. L. R. 637, 638-39 (1979); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461, 485-90 (1978) [hereinafter cited as Plotkin, *Therapeutic Orgy*]; Guardianship of Roe, 383 Mass. 415, 438-39, 421 N.E.2d 40, 53-54 (1981). Even if a patient's mental illness is not exacerbated, certain therapies often cause distressing, and occasionally fatal effects. *Id.*

Furthermore, antipsychotic drug treatment is often abused in state hospitals. See, e.g., *Davis v. Hubbard*, 506 F. Supp. 915, 926 (N.D. Ohio 1980) (use of antipsychotic drugs as punishment); *Rennie v. Klein*, 476 F. Supp. 1294, 1299 (D. N.J. 1979) (hospital use of medication as a form of control and as a substitute for treatment); *Clites v. State*, 322 N.W.2d 917, 921 (Iowa Ct. App. 1982) (expediency program rather than therapeutic program). See generally Baldessarini & Lipinski, *Risks vs. Benefits of Antipsychotic Drugs*, 289 NEW. ENG. J. MED. 427 (1973) (institutional pressures to reduce the number of hospital beds or lengths of hospitalization have led to the "sometimes senseless ritualization of drug therapy" and better use of antipsychotic incorporates them into long term management of complex psychological and medical problems); Zander, *Prolixin Decanoate: Big Brother by Injection?* 5 J. PSYCHIATRY & LAW 55, 67-69 (1977) (the abuse of antipsychotic drugs as a method of control).

2. See generally REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS—VALUES IN CONFLICT (A. Doudera & J. Swazey eds. 1982) (collection of essays prepared by medical and legal experts on issues involved in the right to refute mental health treatment) [hereafter cited as REFUSING TREATMENT].

3. See *infra* notes 12-46 and accompanying text; See also Bonnie, *The Psychiatric Patient's Right to Refuse Medication: A Survey of the Legal Issues*, in REFUSING TREATMENT, *supra* note 2, at 19.

same right. The disagreement stems from a marked difference in values, ethical principles, and practical considerations.⁴ Medical experts are concerned with their ability to treat a group of individuals who generally do not possess the competence adequately to decide their diagnostic futures.⁵ The legal community, however, is concerned with preserving those individuals' right to human autonomy,⁶ equality,⁷ and individualism.⁸

The Massachusetts Supreme Judicial Court indicated deference to those legal concerns in its recent decision in *Rogers v. Commissioner of the Department of Mental Health*.⁹ The supreme judicial court held that patients who are involuntarily committed to state mental hospitals have a right to either accept or refuse treatment by mind-altering drugs personally, or judicially if they have been adjudicated incompetent.¹⁰ The ruling assumes significance because it is the first ruling by the supreme judicial court concerning the use of antipsychotic drugs on institutionalized patients under state law.¹¹ This note examines the supreme judicial court's ruling in *Rogers*. First, it traces the back-

4. See Bonnie, *supra* note 3 at 19-20. See also *infra* notes 97-105, 116-121 and accompanying text.

5. Studies show that more than half of all institutionalized patients are incompetent to give consent, even on such issues as the need for admission. See *Contemporary Studies Project: Facts and Fallacies about Iowa Civil Commitment*, 55 IOWA L. REV. 895, 918 (1970); Brief for Petitioners at 54-68, *Mills v. Rogers*, 457 U.S. 291 (1982). In *Mills v. Rogers*, counsel for defendants argued before the Supreme Court that allowing patients to refuse treatment causes vast administrative problems. He stated: "Allowing a patient to refuse medication will also have an umbrella effect increasing the number of patients relegated to warehoused status in our state hospitals. The failure to forcibly medicate an individual patient refusing medication would affect the entire milieu of a hospital. [O]ne patient refusing medication frequently set off a sort of contagion of refusal." *Id.* But see *Okin v. Rogers*, 478 F. Supp. 1342, 1369-70 (D. Mass. 1979) (where Judge Tauro made findings of fact that his temporary restraining order and preliminary injunctive order had not caused any such effect). Cf. *infra* text accompanying note 164.

6. See *infra* notes 32-45 and accompanying text. See also Ehrlich, *Freedom of Choice: Personal Autonomy and the Right to Privacy*, 14 IDAHO L. REV. 447 (1978); Developments in the Law, *Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1195 n.12 [hereinafter cited as *Civil Commitment*].

7. Where the state allows voluntary patients, whether mentally ill or physically ill, to make their own treatment decisions, but denies the right to involuntarily confined yet competent mental patients, no rational distinction exists and a denial of equal protection may result. See U.S. CONST. amend. XIV, § 1.

8. See authorities cited *supra* note 6.

9. 390 Mass. 489, 458 N.E.2d 308 (1983).

10. *Id.* at 491, 458 N.E.2d at 310.

11. The Massachusetts court, however, has indirectly discussed this issue in previous cases. See *In re Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). See also Note, *Medication and Adjudication: Extending In re Richard Roe III to Institutionalized Psychiatric Patients*, 17 NEW ENG. L. REV. 1029 (1981).

ground and history of the right to refuse medical treatment. Next, it discusses both the substantive rights of involuntarily committed patients and the procedural treatment guidelines as set forth in the *Rogers* decision. Finally, it discusses inherent problems under Massachusetts's present procedure for judicial competency proceedings and substituted judgment treatment decisions.

II. HISTORY OF THE RIGHT TO REFUSE MEDICAL TREATMENT

Both the common law and the Constitution provide bases for an individual's right to refuse medical treatment. The earliest line of decisions which addressed this issue cited the common law principle that individuals are protected from an intentional interference with their physical being.¹² Our ancestors believed that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others. . . ."¹³ Recognized as the common law tort of assault and battery,¹⁴ the theory provided one form of legal action against physicians for unauthorized treatment.¹⁵

Derived from the tort of assault and battery, informed consent developed as a later basis for refusal of treatment.¹⁶ This doctrine espoused the basic principle that "every human being of adult years and

12. See, e.g., *Schloendorff v. Society of N.Y. Hospitals*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (competent adult has right to determine allowable bodily invasions), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957); *Rolater v. Strain*, 39 Okla. 572, 575, 137 P. 96, 97 (1913) (an individual's right to inviolability prevents a physician from interfering with a patient's bodily integrity without consent). Cf. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905). In *Jacobson* the Supreme Court recognized the right of an individual to assert supremacy of his own will in refusing state mandated vaccinations. The Court, however, noted that "in a well-ordered society charged with the duty of conserving the safety of its members, the rights of the individual in respect of his liberty may" be subordinated to society's interest. *Id.* at 29. See generally Plotkin, *Therapeutic Orgy*, *supra* note 1, at 485-90 (discussion of the various common law theories of the right to refuse treatment).

13. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

14. W. PROSSER, *LAW OF TORTS*, § 10, at 36-37 (4th ed. 1971).

15. See *Schloendorff v. Society of N.Y. Hospitals*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957). The court stated that:

[T]he wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

Id.

16. See PROSSER, *supra* note 14 at § 18, 101-102; *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

sound mind has a right to determine what shall be done with his own body."¹⁷ In the oft cited decision of *Canterbury v. Spence*¹⁸ the D.C. Circuit relied on the concept of informed consent. The case involved an action against a physician who performed back surgery on a patient without first informing him of the risk of paralysis.¹⁹ The court stated:

It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery by the physician. And it is evident that it is normally impossible to obtain consent worthy of the name unless the physician first elucidates the options and perils for the patient's edification.²⁰

The application of common law theories to a committed mental patient's right to refuse treatment, however, has been questioned in the past.²¹ A judicial decision to commit was often interpreted as an implicit finding that a person was unable to make treatment decisions.²² Physicians argued, therefore, that commitment without accompanying authority to treat would render the act of hospitalization absurd.²³ The force of the argument, however, is diminished by the more recent recognition that commitment to a mental institution does not automatically render patients legally incompetent to exercise their treatment rights.²⁴ The Third Circuit discussed the modern view in *Rennie v. Klein*²⁵ in which mental health patients sued state officials for injunctive relief from the forcible administration of drugs. The court reasoned that although a person may be mentally ill and involuntarily committed to a state hospital, the law still considers that person competent to some extent.²⁶ It stated that commitment limits but does not

17. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (quoting *Schloendorff v. Society of N.Y. Hospitals*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914), *cert. denied*, 409 U.S. 1064 (1972)).

18. *Id.*

19. *Id.*

20. *Id.* at 783.

21. *Winters v. Miller*, 446 F.2d 65, 74 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971) (Moore, J., concurring in part and dissenting in part). *See also* *Prince v. Sheppard*, 307 Minn. 250, 258-59, 239 N.W.2d 905, 911 (1976) (emphasizing a need for the state to assume the decision making role regarding the psychiatric treatment for one who is unable to rationally do so for himself, presumptively based on the fact of commitment on grounds of mental illness).

22. *See* Plotkin, *Therapeutic Orgy*, *supra* note 1, at 489. *But see*, MASS. GEN. LAWS ANN. ch.123, § 25 (West Supp. 1983).

23. Plotkin, *Therapeutic Orgy*, *supra* note 1, at 489.

24. *See, e.g., Rogers*, 390 Mass. 489, 497, 458 N.E.2d 308, 313-14 (1983); *Rogers v. Okin*, 634 F.2d 650, 658-59 (1st Cir. 1980); *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981).

25. 653 F.2d 836 (3d Cir. 1981).

26. *Id.* at 846.

extinguish an individual's right to be free from confinement and personal intrusion.²⁷ Thus, absent a compelling interest to treat, an involuntarily committed mental patient retains a common law right of action for non-consensual treatment by a private physician.²⁸

In addition to common law origins, constitutional principles such as the right to privacy,²⁹ freedom of thought,³⁰ and protection from cruel and unusual punishment³¹ also support the right to refuse treatment. The much publicized decision in *In re Quinlan*³² first extended the constitutional right to privacy to include the right to refuse medical treatment. The New Jersey Supreme Court allowed the parents of a comatose patient to withdraw her from a mechanical respirator thereby asserting their daughter's right of privacy.³³ Since that decision a number of other courts have recognized the privacy right to

27. *Id.*

28. Case Comment, *The Forcible Medication of Involuntarily Committed Mental Patients with Antipsychotic Drugs—Rogers v. Okin*, 15 GA. L. REV. 739, 756 (1980) [hereinafter cited as Case Comments, *Forcible Medication*]. See *Scott v. Plante*, 532 F.2d 939, 947 (3d Cir. 1976) (patient had a right to refuse Thorazine and, absent an emergency, unconsented to medical treatment is a tort); *Stowers v. Ardmore Acres Hosp.*, 19 Mich. App. 115, 122, 172 N.W.2d 497, 500-01 (1969) (person not adjudged mentally incompetent before commitment had action for assault and battery against treating physician who forcibly injected plaintiff with medication), *aff'd sub nom.*, *Stowers v. Wolodzko*, 386 Mich. 119, 191 N.W.2d 355 (1971).

29. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973); Ehrlich, *supra* note 6; see also notes 32-37 and accompanying text. The right to due process is used as another constitutional basis for the mentally ill to refuse treatment. See Note, *Civil Rights—A Mental Patient's Right Needing Protection*, 57 NOTRE DAME LAW. 406, 412 (1981) [hereinafter cited as Note, *Civil Rights*]. See also *Rennie*, 653 F.2d at 841 n.6 (distinction between refusing treatment on due process grounds or privacy grounds is illusory).

30. The idea, based on the first amendment right to freedom of expression, was recognized in *Stanley v. Georgia*, 394 U.S. 557, 566 (1969). See *infra* notes 38-45 and accompanying text. See also *Abood v. Detroit Bd. of Educ.*, 431 U.S. 209, 235 (1977) ("... in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State").

31. The eighth amendment states that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted." U.S. CONST. amend. VIII. See *infra* notes 42-46 and accompanying text. See generally Symonds, *Mental Patients' Right to Refuse Drugs: Involuntary Medication as Cruel and Unusual Punishment*, 7 HASTINGS CONST. L.Q. 701 (1980) (author discusses the merits of using the eighth amendment prohibition against cruel and unusual punishment as an argument against forced medication of committed patients). The Supreme Court of the United States recognized that forced medication may be a condition of confinement to a mental hospital, requiring due process is necessary before a prisoner is transferred from a jail to a hospital. *Vitek v. Jones*, 445 U.S. 480, 489 (1980).

32. 70 N.J. 10, 355 A.2d 647 (1976).

33. *Id.* at 55, 355 A.2d at 671. The court did raise the competency issue when it noted that under ordinary circumstances the patients right of choice would be based upon her competency to assert it. *Id.*

refuse medical treatment.³⁴ Lower court decisions have suggested that involuntarily committed mental patients could assert the same right absent a compelling state interest;³⁵ the Supreme Court of the United States, however, has declined to consider the issue.³⁶

The first amendment right to freedom of expression provides yet another constitutional basis for the right to refuse medical treatment.³⁷ In the past, patients who sought to refuse medical treatment on religious grounds relied on this argument.³⁸ More recently, however, it has supported the argument that individuals have the right to be free from involuntary mind control.³⁹ Advocates of this position reason that since the first amendment protects the expression of ideas and thoughts, it must be extended to protect an individual's right to generate those ideas and thoughts.⁴⁰ Courts have accepted this reasoning in cases which involve the right of involuntarily committed patients to refuse mental health treatment.⁴¹

The eighth amendment prohibition against cruel and unusual

34. See, e.g., *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980) (competent patient at state mental institution allowed to refuse drug treatment absent danger to himself or others in the institution); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (terminally ill patient was allowed to refuse chemotherapy); *In re Quakenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978) (a competent adult may refuse a leg amputation).

35. See, e.g., *Okin v. Rogers*, 478 F. Supp. 1342, 1360-71 (D. Mass. 1979). See also *Civil Commitment*, *supra* note 6, at 1194; Note, *Mental Health—The Right to Refuse Drug Therapy Under "Emergency Restraining Statutes"*, 11 NEW ENG. L. REV. 509, 535 (1976).

36. *Mills v. Rogers*, 457 U.S. 291, 304-05 (1982).

37. This right to freedom of expression includes both the right of an individual to communicate and the action or process of thinking. See Plotkin, *Therapeutic Orgy*, *supra* note 1, at 494; Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.-C.L. L. REV. 363, 388-96 (1980).

38. See *Winters v. Miller*, 446 F.2d 65, 69-70 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971); *In re Boyd*, 403 A.2d 744, 746 (D.C. Cir. 1979).

39. See *Okin v. Rogers*, 478 F. Supp. 1342, 1367 (D. Mass. 1979); *Kaimowitz v. Michigan Dept. of Mental Health*, No. 73-19434 (Mich. Cir. Ct. 1973), *reprinted in* A. BROOKS, LAW, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM 902, 916-20 (1974) (court accepted this theory in a case in which a state hospital wanted to submit a mental patient to experimental psychosurgery). Cf. *Rennie v. Klein*, 462 F. Supp. 1131, 1143-44 (D.N.J. 1978) (held that if forced medication is appropriate, the temporary dulling of the senses accompanying the medication does not violate the first amendment).

40. Note, *Civil Rights*, *supra* note 29 at 411; See Plotkin, *Therapeutic Orgy*, *supra* note 1, at 494-95.

41. See, e.g., *Rennie v. Klein*, 462 F. Supp. 1131, 1143-44 (D.N.J. 1978). The parties in *Rogers* raised the issue in the U.S. District Court. *Okin v. Rogers*, 478 F. Supp. 1342, 1367 (D. Mass. 1979). The court held that the first amendment right to free expression and thought does include the mental patient's right to be free from involuntary mind control. *Id.* Neither the appellate court, *Rogers v. Okin*, 634 F.2d 650, 654 n.2 (1st Cir. 1980), nor the United States Supreme Court, *Mills v. Rogers*, 457 U.S. 291, 303-06 (1982), however, reached this issue on appeal or certiorari.

punishment⁴² is less frequently cited than first amendment freedom of expression and privacy rights as a basis for refusing medical treatment. The difficulty in relating it to individuals' rights to refuse treatment arises from its normal application in penal rather than medical contexts.⁴³ The Court discussed the principle, however, in *Knecht v. Gillman*⁴⁴ which involved the behavioral medical treatment of prison inmates. The Eighth Circuit held that forcible administration of a pormorphine to induce prolonged and violent vomiting constituted cruel and unusual punishment if used as treatment of inmates' behavioral problems.⁴⁵ The applicability of this particular constitutional argument to involuntarily committed mental patients remains somewhat limited since officials rarely characterize their treatment as "punishment."⁴⁶

II. FACTUAL BACKGROUND OF ROGERS

Rogers originated in 1975 in the United States District Court in Massachusetts as a class action against the Commissioner of the Department of Mental Health, numerous doctors, and administrative staff members at the May and Austin Units of Boston State Hospital.⁴⁷ The plaintiffs, both voluntary and involuntary patients at the Boston Hospital, challenged the constitutionality of forced medication and involuntary seclusion of patients in non-emergency circumstances.⁴⁸ The District Court denied damages⁴⁹ but granted injunctive relief based on its determination that mental patients not adjudicated incompetent possess a constitutional right to refuse treatment in non-emer-

42. U.S. CONST. amend. VIII. See *supra* note 31 for text of this amendment.

43. See, e.g., *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968) (use of strap as disciplinary measure in state penitentiary violates eighth amendment guarantee against cruel and unusual punishment); *Wright v. McMann*, 387 F.2d 519, 525 (2d Cir. 1967) (eighth amendment forbids confining prisoner in bitter cold and depriving him of basic elements of hygiene).

44. 488 F.2d 1136 (8th Cir. 1973).

45. *Id.* at 1140.

46. See Case Comments, *Forcible Medication*, *supra* note 28 at 744-45. *Contra* *Vitek v. Jones*, 445 U.S. 480, 493 (1980); see *supra* note 1 and accompanying text.

47. *Okin v. Rogers*, 478 F. Supp. 1342, 1352 (D. Mass. 1979). The plaintiffs sought injunctive relief, and compensatory and punitive damages. *Id.* at 1352.

48. *Id.* The plaintiffs' arguments focused on their constitutional right to refuse treatment. They conceded, however, that their right is not absolute but rather one which is subordinate to the hospital's right to provide emergency care when the safety of the individual patient, or other patients, is threatened.

49. *Id.* at 1375-89. The court made various findings of fact and conclusions of law concerning the defendants' treatment and seclusion practices. It determined that on the basis of the evidence submitted, the plaintiffs failed to prove that defendants' treatment and seclusion practices were not in accordance with acceptable medical standards. *Id.* at 1389.

gency situations.⁵⁰ Further, it held that in the event of an adjudication of incompetence, patients' guardians could exercise any rights to make treatment decisions which the patient possessed.⁵¹

On appeal, the First Circuit affirmed the denial of damages,⁵² but vacated and remanded the issue of injunctive relief.⁵³ The court indicated that physicians could use their discretion in deciding to administer drugs forcibly, but only after balancing the interests of the patients against the State's interest in preventing violence within the institution.⁵⁴ Furthermore, the court expanded the definition of an "emergency" situation in which patients could be treated against their will,⁵⁵ and held that state officials need not seek a guardian's approval for individual treatment decisions.⁵⁶ Thus, the appellate court decision allowed physicians greater latitude in treatment decisions than did the District Court; it retained, however, the requirement of a judicial determination of incapacity to decide treatment decisions in non-emergency situations.⁵⁷

The United States Supreme Court granted certiorari to determine whether an involuntarily committed mental patient possesses a constitutional right to refuse treatment with antipsychotic drugs.⁵⁸ The Supreme Court, however, refused to rule on the constitutional issue. Rather, it vacated and remanded the case to the circuit court for a

50. *Id.* at 1365-67. The judge enjoined the defendants from forcibly medicating patients except in an "emergency" which the judge defined as "circumstances in which a failure [to treat] . . . would bring about a substantial likelihood of physical harm to the patients or others". *Id.* at 1371.

51. *Id.* at 1364.

52. *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980). The plaintiffs appealed the denial of damages by the District Court and the defendants questioned the parameters of the injunctive relief in a cross-appeal.

53. *Id.* at 653. Judge Coffin stated that the circuit court was in "substantial agreement with portions of the district court's reasoning" but it was necessary to modify several important aspects of the lower court's ruling. *Id.*

54. *Id.* at 656-57. The court stated that the District Court's "substantial likelihood of physical harm" standard was too narrow. *Id.* at 659-60.

55. *Id.* "Emergency" included those situations in which an incompetent patient's health would significantly deteriorate without medication. *Id.* The court gave no guidance, however, on what this standard meant or how it could be applied.

56. *Id.* at 661.

57. *Id.*

58. *Mills v. Rogers*, 457 U.S. 291, 293 (1982). Defendants petitioned the Supreme Court to review the First Circuit ruling that involuntarily committed patients may refuse antipsychotic drug treatment. Defendants stressed two basic reasons why the court should not recognize such a right. First, the right of refusal would impair the state's interest in maintaining order and treating other patients. Brief for Petitioners at 54-68, *Mills v. Rogers*, 457 U.S. 291 (1982). Second, the original commitment decision would act as a sufficient predicate for administering drug treatment. *Id.*

determination of committed patients' rights, both substantively and procedurally, under Massachusetts law.⁵⁹ On remand, the First Circuit court certified nine questions to the Supreme Judicial Court of Massachusetts.⁶⁰

III. THE ROGERS V. COMMISSIONER DECISION

The supreme judicial court's decision in *Rogers* extended the right to refuse treatment with antipsychotic drugs to institutionalized patients in Massachusetts.⁶¹ Although the supreme judicial court previously speculated on that right in *Guardianship of Roe*,⁶² *Rogers* is the first ruling on the issue under Massachusetts common and statutory law.⁶³ The unanimous opinion, written by Justice Abrams, divided the nine certified questions into four groups. Discussion follows which addresses each of those groups individually.

A. *Competence of Involuntarily Committed Patients to Make Treatment Decisions; Judicial Determination of Incompetence*⁶⁴

The supreme judicial court concluded in *Rogers* that, except in an

59. *Mills v. Rogers*, 457 U.S. 291, 305-06 (1981). The court stated that in theory it could "define the scope of a patient's federally protected liberty interest without reference to state law." It indicated, however, that the "substantive rights provided by the Federal Constitution define *only* a minimum." *Id.* at 300 (emphasis added). Further, the court stated that the state law recognize liberty interests which are more extensive than federal rights. *Id.* The court decided, therefore, to remand the case to the circuit court for a determination of the plaintiffs' rights under state law. *Id.* at 306.

The Supreme Court's decision to remand was also influenced by the supreme judicial court's decision in *Roe* which was decided while the *Mills* case (see *supra* note 58) was before the Supreme Court. On remand, the circuit court was to determine how *Roe* may have changed or defined Massachusetts law and whether that decision required a revision of its decision or certification of dispositive state-law questions to the Supreme Judicial Court of Massachusetts. *Id.*

60. *Rogers v. Commissioner*, 390 Mass. at 494, 458 N.E.2d at 312.

61. *Id.* at 489, 458 N.E.2d 308 (1983).

62. 383 Mass. 415, 441-42, 421 N.E.2d 4055 (1981).

63. *Rogers*, 390 Mass. at 494 n.7, 458 N.E.2d at 312 n.7. The court indicated that since the Supreme Court's opinion was predicated on the decision in *Roe*, the answers to the certified questions were controlled under statutory and common law and thus the court did not discuss the issues under the state constitution. *Id.*

64. *Id.* at 494, 458 N.E.2d at 312. This section of the opinion addressed the first three certified questions concerning "Non-Emergency Situations":

1. Under state law, does the civil involuntary commitment of a person to a mental institution constitute a determination of incompetency to make treatment decisions?

2. If not, does state law, in the absence of an emergency justifying exercise of the state's police power or an imminent threat to a patient's condition justifying exercise of the state's *parens patriae* power, require a probate court

"emergency,"⁶⁵ a judicial adjudication of incompetence to make treatment decisions must precede any determination to override patient's rights to make their own treatment decisions.⁶⁶ The court clearly indicated that commitment to a mental institution under Massachusetts law does not indicate incompetence to make treatment decisions.⁶⁷ The court noted that Massachusetts statutes instead "comprehend" the competence of an involuntarily committed patient to make treatment decisions.⁶⁸

The court derived its conclusions from various sections of Massachusetts General Laws Annotated chapter 123⁶⁹ and from previous case law.⁷⁰ Section twenty-five of chapter 123 states that an individual is not deemed incompetent to manage his own affairs solely by reason of admission or commitment to a mental health facility.⁷¹ The court noted that two factors control civil commitment in Massachusetts: 1) a finding of mental illness; and 2) a showing that failure to commit the person would create a likelihood of serious harm.⁷² The court in-

finding of incompetence and appointment of a guardian as the exclusive method for determining incompetency to make treatment decisions?

3. If, in the circumstances described in question no. 2, probate proceedings are not the exclusive method for determining incompetency to make treatment decisions, what other procedure or procedures may be sufficient under state law? *Id.* at 494 & n.8, 458 N.E.2d at 312 & n.8.

65. The court defined emergencies as situations in which "a patient poses an imminent threat of harm to himself or others," and only if there is no less intrusive alternatives to antipsychotic drugs. *Id.* at 510-11, 458 N.E.2d at 321-22.

66. *Id.* at 498, 458 N.E.2d at 314. See, e.g., *Rennie*, 653 F.2d at 846; *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971).

67. *Id.* at 497, 458 N.E.2d at 314. See *Roe*, 383 Mass. at 442 & n.15, 421 N.E.2d at 55 & n.15 ("a person is presumed to be competent unless shown by the evidence not to be competent," even while committed to a public or private institution); *Boyd v. Registrars of Voters of Belchertown*, 368 Mass. 631, 635-36, 334 N.E.2d 629, 632 (1975) (residence at Belchertown State School does not itself render person incompetent).

68. *Rogers*, 390 Mass. at 496, 458 N.E.2d at 313.

69. MASS. GEN. LAWS ANN. ch.123, §§ 1, 7, 8, 25 (West Supp. 1983).

70. See, e.g., *Matter of Moe*, 385 Mass. 555, 432 N.E.2d 712 (1982); *Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981).

71. MASS. GEN. LAWS ANN. ch.123, § 25.

No person shall be deemed to be incompetent to manage his own affairs, to contract, to hold professional or occupational or vehicle operators licenses or to make a will solely by reason of his admission or commitment in any capacity to the treatment or care of the department or to any public or private facility, nor shall departmental regulations restrict such rights.

Id.

72. *Rogers*, 390 Mass. at 495, 458 N.E.2d at 312. See MASS. GEN. LAWS ANN. ch.123, § 7(a) (West Supp. 1983) which states: "The superintendent of a facility may petition the district court . . . for the commitment . . . of any patient at said facility whom said superintendent determines that the failure to hospitalize would create a likelihood of serious harm by reason of mental illness." *Id.* See also MASS. GEN. LAWS ANN. ch.123,

interpreted the factors as requiring "no adjudication of judgmental capacity." The court concluded, therefore, that no requirement exists that a person be incompetent in order to be committed.⁷³

Given that one statutory definition specifically includes "judgment" as a criteria for a finding of "likelihood of serious harm,"⁷⁴ the court interpreted the two factors liberally. The definitions of "[l]ikelihood of serious harm" in section one of chapter 123 include a "very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community."⁷⁵ The court dismissed the relevance of this definition by stating that "[it] says nothing concerning . . . competence to make treatment decisions."⁷⁶

In addition to considering the sections of Chapter 123 which address the criteria for civil commitment, the court examined those sections which relate to patients' rights to manage their own affairs.⁷⁷ This right exists for patients under the present statutory scheme.⁷⁸ It encompasses the right to make basic decisions concerning personal care and maintenance of physical and mental health.⁷⁹ The court in *Rogers* concluded, therefore, that the right to make specific treatment

§ 8(a) (West Supp. 1983) which states "[a]fter a hearing . . . the district court shall not order the commitment of a person at a facility . . . unless it finds after a hearing that (1) such person is mentally ill, and (2) the discharge of such person from a facility would create a likelihood of serious harm." *Id.*

73. *Rogers*, 390 Mass. at 495, 458 N.E.2d at 313.

74. Section 1, the definitional section of Chapter 123, lists three different definitions for "likelihood of serious harm";

(1) [A] substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

MASS. GEN. LAWS ANN. ch.123, § 1 (West Supp. 1983).

The court summarily dismissed the first two definitions as "provid[ing] no adjudication of judgmental capacity." *Rogers*, 390 Mass. at 495, 458 N.E.2d at 313 (quoting *Rogers v. Okin*, 634 F.2d at 658). The court stated that commitment under these two definitions "is based on a determination of risk of physical harm to the individual or to others." *Id.*

75. MASS. GEN. LAWS ANN. ch.123, § 1 (West Supp. 1983).

76. *Rogers*, at 495, 458 N.E.2d at 313.

77. *Id.* at 494-96, 458 N.E.2d at 312-14.

78. See MASS. GEN. LAWS ANN. ch.123, § 25 (West Supp. 1983).

79. *Fazio v. Fazio*, 375 Mass. 394, 403, 378 N.E.2d 951, 957 (1978).

decisions derives from the patients' right to manage their affairs.⁸⁰ Only after a judge, through an incompetency proceeding,⁸¹ finds patients incapable of taking care of themselves by reason of mental illness do these decisions become the responsibility of an appointed guardian, rather than the patients.⁸²

The court proceeded to reject defendant's argument that doctors should make treatment decisions for involuntarily committed patients, whether competent or not.⁸³ It had previously held in *Harnish v. Children's Hospital Medical Center*⁸⁴ "that every competent adult has a right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks despite the views of the medical profession."⁸⁵ Accordingly, since involuntarily committed patients are presumed competent, until adjudicated otherwise, both case law and statutory law dictate that they possess the right to refuse treatment.⁸⁶

B. *The Decision to Treat Incompetent Mental Patients with Antipsychotic Drugs*⁸⁷

The court began its discussion of the use of antipsychotic drugs on incompetent mental patients with the premise that a general right exists to refuse medical treatment in appropriate circumstances.⁸⁸ The court stated that "the recognition of that right must extend to the cases of an incompetent, as well as a competent, patient because the

80. *Rogers*, at 496, 458 N.E.2d at 313.

81. See MASS. GEN. LAWS ANN. ch.201, § 6 (West Supp. 1983).

82. *Rogers*, at 497, 458 N.E.2d at 314.

83. *Id.*

84. 387 Mass. 152, 154, 439 N.E.2d 240, 242 (1982).

85. *Id.* (quoting *Wilkinson v. Vesey*, 110 R.I. 606, 624, 295 A.2d 676, 687 (1972)).

86. *Rogers*, at 498, 458 N.E.2d at 314.

87. The section addressed certified questions 4 and 5 concerning "Non-emergency Situations":

4. If a proper determination of incompetency to make treatment decisions has been made, and in the absence of an emergency justifying exercise of the state's police power or an imminent threat to a patient's condition justifying exercise of the state's *parens patriae* power, under state law must there be a substituted judgment decision, or other decision by a person aside from the incompetent, prior to the administration of psychotropic drugs?

5. If so, who may make such a decision, what procedures must be followed, and what factors must be considered?

Id. at 499 n.13, 458 N.E.2d at 315 n.13.

88. *Rogers*, 390 Mass. at 499, 458 N.E.2d at 315. See *supra* notes 12-46 and accompanying text. See also *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 745-46, 370 N.E.2d 417, 427-28 (1977); Gaughan and LaRue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution*, 4 LAW AND PSYCHOLOGY REV. 43, 74 (1978).

value of human dignity extends to both.”⁸⁹ The court concluded, therefore, that if an involuntarily committed patient refuses anti-psychotic drug treatment and is subsequently adjudicated incompetent, those charged with his or her protection must seek a judicial substituted judgment decision.⁹⁰

Under the substituted judgment standard, the guardian or doctors for incompetent involuntarily committed patients must petition the court for a substitute judgement by a judge concerning the treatment decision.⁹¹ The judge must determine “with as much accuracy as possible” the wants and needs of the individuals involved.⁹² As the court in *Rogers* indicated, the decision should be that which would have been made by the individual patients, if they had been competent.⁹³

The use of this standard in *Rogers* extended the supreme judicial court’s decision in *Matter of Moe*⁹⁴ which involved the issue of sterilization. In *Moe*, the court held that guardians must acquire prior judicial approval before they may consent to or refuse proposed “extraordinary” medical treatment.⁹⁵ Since psychotropic drug treatment was characterized as extraordinary at the time, the court in *Rogers* mandated court approval before forcible medication of an incompetent patient in nonemergency situations.⁹⁶

The supreme judicial court, moreover, rejected use of the “medical model” approach to a substituted judgment.⁹⁷ Under the procedure, a qualified physician rather than a judge would make the

89. *Rogers*, 390 Mass. at 499-500, 458 N.E.2d at 315 (quoting *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 745-46, 370 N.E.2d 417, 427-28 (1977)).

90. *Id.* at 501-02, 458 N.E.2d at 316. The court indicated in a footnote that its decision focused on patients who refuse treatment, because the issue generally arises in that context. *Id.* at 500 n.14, 458 N.E.2d at 315 n.14. Further, the court noted that because incompetent patients cannot meaningfully consent, a substituted judgment should be undertaken for them even if they accept the medical treatment. *Id.*

91. *See Roe*, 383 Mass. at 434-35, 421 N.E.2d at 51-52.

92. *Id.* *See Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 750, 370 N.E.2d 417, 430 (1977).

93. *Rogers*, 390 Mass. at 500, 458 N.E.2d at 316.

94. 385 Mass. 555, 559, 432 N.E.2d 712, 716 (1982). *See also Matter of Spring*, 380 Mass. 629, 639, 405 N.E.2d 115, 122 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 750-51, 370 N.E.2d 417, 430-31 (1977); *Guardianship of Basset*, 7 Mass. App. Ct. 56, 61, 385 N.E.2d 1024, 1028 (1979); *Lane v. Candura*, 6 Mass. App. Ct. 377, 385, 376 N.E.2d 1232, 1236 (1978).

95. *Moe*, 385 Mass. at 559, 432 N.E.2d at 712; *See Roe*, 383 Mass. at 436-40, 421 N.E.2d at 51-55 (court discusses why psychotropic drugs are considered “extraordinary” treatment).

96. *Rogers*, 390 Mass. at 501-02, 458 N.E.2d at 316.

97. *Id.* at 502, 458 N.E.2d at 317.

substituted judgment.⁹⁸ The American Psychiatric Association, which filed an amicus curae brief in the case, claimed that the "medical model" would protect incompetent patients' civil rights to refuse treatment, while providing the hospital with a qualified medical opinion as the basis for the substituted judgment.⁹⁹ Further, the Association argued that the "medical model" would provide flexibility in hospital administration and avoid the adversarial quality of judicial proceedings.¹⁰⁰

The court disagreed with these arguments.¹⁰¹ It stated that "no medical expertise is required [for making the substituted judgment decision], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the individual would, if he were competent."¹⁰² The court cited inherent conflicts of interest as another argument against use of the medical model.¹⁰³ It reasoned that doctors must maintain order in the hospital as well as treat patients, and therefore have interests in conflict with their patients who wish to avoid medication.¹⁰⁴ A number of courts and commentators have voiced these same concerns.¹⁰⁵

Once the supreme judicial court in *Rogers* mandated a judicial substituted judgment for incompetent institutionalized patients who have refused treatment, it enumerated six factors to be considered by the judge in arriving at the substituted judgment:¹⁰⁶ the patients' expressed preferences regarding treatment;¹⁰⁷ the extent of the patients'

98. *Id.* But see *Quinlan*, 70 N.J. 10, 35, 355 A.2d 647, 661 (1976).

99. *Rogers*, 390 Mass. at 502, 458 N.E.2d at 317.

100. *Id.*

101. *Id.*

102. *Id.* (quoting *Roe*, 383 Mass. at 435, 421 N.E.2d at 52).

103. *Rogers*, 390 Mass. at 503, 458 N.E.2d at 317. The court in *Roe* listed "likelihood of conflicts" as one of five factors to be considered in determining the necessity a judicial substituted judgment decision. The other factors included: (1) the intrusiveness of the proposed treatment, (2) the possibility of adverse side effects, (3) the absence of emergency, (4) and the nature and extent of prior judicial involvement. *Roe*, 383 Mass. at 436, 421 N.E.2d at 52. The court did not address all these factors in its opinion in *Rogers*. For a more detailed discussion, see *Roe*, 383 Mass. at 436-43, 421 N.E.2d at 52-58.

104. *Rogers*, 390 Mass. at 503 & n.19, 458 N.E.2d at 317-18 & n.19.

105. See *supra* text accompanying note 1.

106. *Rogers*, 390 Mass. at 505-7, 458 N.E.2d at 318-19.

107. *Id.* at 505, 458 N.E.2d at 318 (quoting *Roe*, 383 Mass. at 444-45, 421 N.E.2d at 57). This factor is ironic given that the substituted judgment decision usually takes place after patients have refused treatment. As the court noted, however, patients may have expressed their preferences before being adjudicated incompetent. *Id.* If made while competent, such a preference receives great weight unless evidence indicates that the patients would have changed their opinions under normal circumstances. *Id.* Further, even if the patients state the preference while incompetent, it is treated as a "critical factor in the

religious convictions;¹⁰⁸ the impact of the decision on the patients' family;¹⁰⁹ the probability of adverse side effects;¹¹⁰ the prognosis without treatment;¹¹¹ and the prognosis with treatment.¹¹² If the judge orders treatment after considering these factors, he or she should then authorize a treatment plan¹¹³ which is subject to periodic review by the court.¹¹⁴

C. "Police Power" and the Use of Antipsychotic Drugs¹¹⁵

The third portion of the court's opinion weighed the institutional

determination of (their) best interests." *Id.* (quoting *Doe v. Doe*, 377 Mass. 272, 277-79, 385 N.E.2d 995, 1000 (1979)).

108. *Id.* The court considers patients' religious beliefs "to the extent . . . they may contribute to . . . [the] refusal of treatment." *Id.* As the supreme judicial court stated "[t]he question to be addressed is whether certain tenets or practices of the incompetent's faith would cause him individually to reject the specific course of treatment proposed for him in his present circumstances" *Id.* See also cases cited *supra* note 38.

109. *Rogers*, 390 Mass. at 505-6, 458 N.E.2d at 319. This factor takes into account the burdens of cost and time on the patient's family for home care or institutional care. The focus of this inquiry, however, remains on what the patient would choose if competent. *Id.*

110. *Id.* at 506, 458 N.E.2d at 319. This entails an analysis of the "severity of these side effects, the probability that they would occur, and the circumstances in which they would be endured." *Id.* (quoting *Roe*, 383 Mass. at 447, 421 N.E.2d at 58). See *supra* note 1 for a description of the adverse effects of antipsychotic drugs. See also Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1726-27 (1982); Brooks, *The Constitutional Right to Refuse Antipsychotic Medication*, 8 BULL. AM. ACAD. OF PSYCHIATRY & LAW 179, 183 (1980).

111. *Rogers*, 390 Mass. at 506, 458 N.E.2d at 319 (quoting *Roe*, 383 Mass. at 447-48, 421 N.E.2d at 58-59). The court noted that probably most patients would wish to avoid a steadily worsening condition. The court stipulated, however, that the judge must reach an individualized conclusion based on the unique "perspective of the incompetent person." *Id.*

112. *Id.* The likelihood of improvement or cure would most likely influence patients' treatment decisions. *Id.*

113. *Id.* at 506-07, 458 N.E.2d at 319. The court noted that the treatment plan should include various specifically identified medications which would be administered over a long period of time. *Id.*

114. *Id.* The review is needed so that the court can determine whether the condition of the patient has substantially changed. *Id.* at 507, 458 N.E.2d at 319. Once the court order has issued, the burden shifts to the incompetent patient's guardian to seek modification of the order. *Id.*

115. The section addressed certified questions 6 and 7:

Non-emergency Situations

6. Under state law, after a proper decision to refuse medication has been made, what state interest or interests would be sufficiently compelling to overcome the interest of the individual in refusing treatment with antipsychotic drugs?

Emergency Situations

7. What standards and procedures are required under state law to make a decision forcibly to medicate involuntarily committed patient under the state's police power?

concerns of the defendants against the plaintiffs' right of self-determination. Defendants argued that the limitation of their ability to medicate creates unfortunate side effects: "hospital administration becomes more difficult, lengths of stay increase, fewer patients are treated, staff turnover increases, and new personnel become more difficult to attract."¹¹⁶ The court indicated, however, that the patients' rights to make treatment decisions¹¹⁷ and to be free from the potential abuse of medication for administrative convenience¹¹⁸ outweighed the listed institutional considerations.

The court did recognize that hospitals must protect third persons as well as the patients themselves while preserving security within the institution.¹¹⁹ It noted, however, that administering drugs for these reasons necessitates strict compliance with the statutory and regulatory conditions for use of chemical restraints.¹²⁰ These conditions permit restraint of mental health patients only in cases of emergency such as extreme violence, personal injury, or attempted suicide, or the serious threat of any of the foregoing.¹²¹

The court made very clear that neither hospital physicians nor the courts could vary these standards.¹²² *Only* if patients pose an imminent threat of harm to themselves or others and *only* if no less intrusive alternative exists may the Commonwealth invoke its police powers without prior court approval to treat patients by forcible medication of antipsychotic drugs.¹²³

Id. at 507 n.23, 458 N.E.2d at 319-20 n.23.

116. *Id.* at 507, 458 N.E.2d at 319-20.

117. *Id.* at 507, 458 N.E.2d at 320. *See* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741-45, 370 N.E.2d 417, 426-27 (1977); *Contra* Commissioner of Corrections v. Myers, 379 Mass. 255, 266, 399 N.E.2d 452, 459 (1979) (prisoner's refusal of kidney dialysis may be subordinated to need to operate prison in orderly manner).

118. *Rogers*, 390 Mass. at 508, 458 N.E.2d at 520. The court listed numerous law review articles and cases which detail the abuse of antipsychotic drugs for administrative convenience, punishment, and restraint. *Id.* at 508-09, 458 N.E.2d at 320-321. *See also supra* text accompanying note 1.

119. *Rogers*, 390 Mass. at 509, 458 N.E.2d at 321.

120. *Id.* *See* MASS. GEN. LAWS ANN. ch.123, § 21 (West Supp. 1984). *See also* 104 MASS. ADMIN. CODE, tit. 104, § 3.12 (2) (1978). "Restraint or seclusion of patients may be used only in emergency situations where there is the occurrence or serious threat of extreme violence, personal injury, or attempted suicide." Further, those regulations define "restraint" to include mechanical, chemical, and therapeutic restraints. *Id.* § 3.12 (3).

121. MASS. GEN. LAWS ANN. ch.123, § 21 (West Supp. 1984). The court indicated in a footnote to its decision that it adhered to the definition of emergency as stated in *Roe*: "unforeseen combination of circumstances or the resulting state that calls for immediate action." *Rogers*, 390 Mass. at 509 n.25, 458 N.E.2d at 321 n.25 (quoting *Roe*, 383 Mass. at 440, 421 N.E.2d at 40).

122. *Rogers*, 390 Mass. at 510-11, 458 N.E.2d at 321-22.

123. *Id.* (emphasis added). *Cf.* Bonnie, *supra* note 3, at 24 (author argues that the

D. *Forcible Antipsychotic Medication Essential to Prevent "Immediate, Substantial, and Irreversible Deterioration of a Serious Mental Illness"*¹²⁴

The supreme judicial court reiterated in *Rogers* its rejection of the use of the commonwealth's parens patriae power¹²⁵ "to do what is 'best' for citizens despite their own wishes."¹²⁶ The substituted judgment standard remains the norm in Massachusetts.¹²⁷ In *Guardianship of Roe*, the court outlined the rare circumstances in which Massachusetts may invoke its parens patriae power and override patients' refusals of medication absent the threat of violence.¹²⁸ It stated that noninstitutionalized patients may be treated against their will to prevent the "immediate, substantial and irreversible deterioration of a serious mental illness."¹²⁹

The *Rogers* ruling extended this standard to include the institutionalized patient. The court stressed, however, that only "interim treatment" is allowed under such situations.¹³⁰ After patients are medicated to avoid immediate deterioration, if doctors wish to continue such medication, they must first acquire judicial adjudications of the patients' incompetence.¹³¹ Such adjudication can be conducted through an expedited hearing process provided by Massachusetts law.¹³² If the judge determines that the involuntarily committed pa-

emergency exception actually represents an end-run around both the police power ideology and self-determination principles).

124. The final two certified questions the court addressed were as follows:

Emergency Situations

8. Under state law is there a parens patriae state interest in situations where the delay that would be occasioned by ordinary recourse to the properly designated decisionmaker could cause a serious deterioration of the patient?

9. If so, under state law, what procedures must be followed and what standard of decisionmaking must be applied to those situations?

Rogers, 390 Mass. at 511 n.27, 458 N.E.2d at 322 n.27.

125. "Parens patriae originates from the English common law where the King had a royal prerogative to act as guardian to persons with legal disabilities." Although limited by recent laws and court decisions, the parens patriae power in the United States belongs with the states. BLACK'S LAW DICTIONARY 1003 (5th ed. 1979).

126. *Rogers*, 390 Mass. at 511, 458 N.E.2d at 322. The court relied on its decision in *Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40, in which it indicated that the state's "interest in requiring its residents to function at their maximum capacity" does not outweigh the fundamental individual rights asserted therein. *Rogers*, 390 Mass. at 511, 458 N.E.2d at 322.

127. *Rogers*, 390 Mass. at 511, 458 N.E.2d at 322.

128. *Guardianship of Roe*, 383 Mass. at 448-49, 421 N.E.2d at 59.

129. *Id.* at 441, 421 N.E.2d at 55.

130. *Rogers*, 390 Mass. at 512, 458 N.E.2d at 322.

131. *Id.*

132. See MASS. GEN. LAWS ANN. ch.201, §§ 7, 14 (West 1958); MASS. P. CT. R. 29.

tients are incompetent, he or she must then make a substituted judgment concerning treatment.¹³³

IV. IMPLICATIONS

The supreme judicial court's decision reflects the general recognition that mental illness does not automatically render individuals incapable of rational decisionmaking.¹³⁴ Psychiatric literature has documented many forms of mental illness which impact specifically on affected individuals, leaving decisionmaking capacities and reasoning abilities unimpaired.¹³⁵ Under the *Rogers* decision, Massachusetts physicians must respect those abilities and allow patients to manage their personal affairs.¹³⁶ Physicians may disregard the rule only in emergency situations or when a judge in an incompetency hearing adjudicates patients as incompetent.¹³⁷ If patients are determined incompetent, the court must then make a substituted judgment treatment decision.¹³⁸ Thus, the judiciary is called upon not only to determine what constitutes "competency" in terms of treatment decisions but also to ascertain what treatment decision incompetent patients would have made, if competent.

It is a difficult task at best to determine whether individuals are competent given that no real clinical, medical, or psychiatric criteria exist for determining competence.¹³⁹ Factors cited as appropriate to the finding include: the patients' knowledge that they have choices to make; their abilities to understand the available options; their cogni-

133. *Rogers*, 390 Mass. at 512, 458 N.E.2d at 322.

134. *Id.* at 496-98, 458 N.E.2d at 313-14. *See Roe*, 383 Mass. 415, 442, 421 N.E.2d 40, 55 (a person is presumed competent even though committed to a public or private institution).

135. *See, e.g., J. PAGE, PSYCHOPATHOLOGY: THE SCIENCE OF UNDERSTANDING DEVIANCE* 32-35 (1971). The Federal District Court in *Rogers* stated that the weight of evidence persuaded the court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that are associated with psychotropic medication. *Okin v. Rogers*, 478 F. Supp. 1342, 1361 (D. Mass. 1979).

136. *Rogers*, 390 Mass. at 496, 458 N.E.2d at 313. The court stated that the right to make treatment decisions is an essential element of the patient's general right "to manage his affairs." *Id.* *See MASS. GEN. LAWS ANN.* ch.111, § 70E (1983), which enumerates patients' rights "to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care," *id.* at § 70E(h), and to informed consent to the extent provided by law." *Id.* at § 70E(i).

137. *See MASS. GEN. LAWS ANN.* ch.201, § 6 (West Supp. 1983).

138. *See supra* notes 101-08 and accompanying text.

139. Michels, *Competence to Refuse Treatment*, in *REFUSING TREATMENT*, *supra* note 2, at 115.

tive capacities to consider the relevant factors; the absence of interfering pathologic or emotional states; their awareness of other views and attitudes concerning the decision; and an understanding of their reasons for deviating from standard views.¹⁴⁰ Massachusetts incompetency proceedings focus on whether patients are incapable of taking care of themselves by reason of mental illness.¹⁴¹ Under the statutory proceeding, the court is at liberty to hear medical testimony and to submit individuals to psychiatric examinations.¹⁴² Thus, the considerations deemed relevant to an incompetency finding rely heavily on medical opinion.

The court in *Rogers* noted that the incompetency proceeding under Massachusetts law is the *only* procedure available for determining that patients lack the capacity to make treatment decisions.¹⁴³ Limited by the structure of the certification procedure, the court's analysis did not address the inadequacies of the present statutory procedure.

While due process protections are required in determining the competency issue,¹⁴⁴ no agreement exists as to the necessity or adequacy of judicial decisions. One physician has noted that the competency determination requires a subtle assessment of patients' reasons for refusing medication.¹⁴⁵ Furthermore, the practical meaning of competency requires clinical rather than legal expertise because it draws on the values of therapeutic need and relative risk.¹⁴⁶ The existence of conflicts between hospital staffs and patients does indicate the need for neutral evaluation or an independent decisionmaker.¹⁴⁷ A judge, removed from the clinical milieu, provides a neutral or independent decision, but the decision will not necessarily reflect clinical expertise or address the needs of the patient.

The use of an independent panel of psychiatrists presents an alternative to the commonwealth's judicial determination of competence and would provide neutral decisionmaking and clinical expertise without requiring judicial involvement. The district court outlined such a

140. *Id.* at 117-18.

141. MASS. GEN. LAWS ANN. ch.201, § 6 (West Supp. 1984). See *Fazio v. Fazio*, 375 Mass. 394, 378 N.E.2d 951 (1978).

142. MASS. GEN. LAWS ANN. ch.201, § 6 (West Supp. 1983).

143. *Rogers*, 390 Mass. at 497, 458 N.E.2d at 314, (emphasis added).

144. See, e.g., *Rennie v. Klein*, 462 F. Supp. at 1147; *Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976); *Clonce v. Richardson*, 379 F. Supp. 338, 348-49 (W.D. Mo. 1974). See also Plotkin, *supra* note 12, at 491.

145. Bonnie, *supra* note 3, at 27.

146. *Id.*

147. See *supra* notes 103-05 and accompanying text.

procedure with its injunctive order in *Rennie v. Klein*.¹⁴⁸ The court ordered the State Commissioner of the Department of Mental Health to appoint psychiatrists to serve on a panel.¹⁴⁹ The appointed psychiatrists retain their independent status as decisionmakers—that is, they do not treat the patients who come before the panel for competency evaluations.¹⁵⁰ The court reasoned that a psychiatrist would be more effective than a judge, lawyer, or layperson in the independent decisionmaker role.¹⁵¹

The *Rennie* court's proposal represents a strong argument in favor of the use of a panel of psychiatrists, thus avoiding the untimely delays and adversarial nature inherent in the present judicial competency proceeding in Massachusetts. As one attorney recently argued, the competency hearing is largely duplicative since most involuntarily committed patients have recently had commitment hearings.¹⁵² Further, the costs of such hearings will be significant in terms of treatment staff diverted from the hospital.¹⁵³ More importantly, it remains uncertain whether judicial competency hearings will assure effective patient treatment.¹⁵⁴ Considering crowded court dockets and the amount of time needed for the process itself—i.e. notice, appointment of an attorney, hearing time—considerable time will elapse before the procedure will be completed. During this period, the patient will remain involuntarily committed without treatment. Such a situation not only causes administrative problems for the hospital but also allows patients' health to deteriorate while under the care of the State.¹⁵⁵

148. 462 F. Supp. 1131, 1147-48 (1978).

149. *Id.* at 1147.

150. *Id.* at 1148.

151. *Id.* at 1149. See *Comey, Patient's Rights: Too Much Courting, Not Enough Caring*, in *REFUSING TREATMENT*, *supra* note 2, at 53. The use of proceedings similar to administrative hearings is another alternative to judicial incompetency proceedings and substituted judgment treatment decisions. Rhoden, *supra* note 37 at 406. An administrative officer, rather than a judge, would hold hearings limited to the issue of incompetency to make treatment decisions. *Id.* If patients are found incompetent, hearing officers, having heard evidence on the need for treatment and patients' reasons for refusing treatment, could then conveniently proceed to make treatment decisions for patients' whose refusals were found incompetent. *Id.* Rhoden argued that consistency, knowledgeability, and neutrality could be assured since an unbiased, expert administrative officer would both assess incompetency and make treatment decisions. *Id.* Although such an administrative procedure would not burden the state court system as much as the present procedure in Massachusetts does, its disadvantages parallel those inherent in formal judicial competency proceedings; e.g., the adversary nature of the proceedings and their untimeliness.

152. *Comey, supra* note 151, at 53.

153. *Id.* See *supra* text accompanying notes 116-18.

154. *Comey, supra* note 151, at 53.

155. See *Gill, Side Effects of a Right to Refuse Treatment Lawsuit; Boston State Hospital Experience*, in *REFUSING TREATMENT*, *supra* note 2, at 84; *Nelson, Should There be a*

Many of the arguments proffered by opponents of judicial competency proceedings similarly apply to substituted judgment treatment decisions required by the *Rogers* court. Again, the timeliness of the court process in reaching the substituted treatment decision could result in more unnecessary suffering by the committed patient.¹⁵⁶ Another argument states that judges simply are not equipped to make medical treatment decisions and that these decisions are best left to the physician and family.¹⁵⁷ Furthermore, since courts tend to structure any procedure as an adversary process, a judicial treatment decision will likely create stress and competition between mental patients and their doctors, rather than encourage treatment.¹⁵⁸

The supreme judicial court in *Rogers* addressed the concern over time-laden judicial proceedings by creating two exceptions to the requirement of judicial approval prior to involuntary treatment. These exceptions encompassed the "emergency" situation, i.e., when the patient harms, or threatens to harm, himself or others,¹⁵⁹ and the situation in which treatment is needed to prevent "immediate, substantial, and irreversible deterioration of a serious mental illness."¹⁶⁰

The exceptions, however, do not dispel other concerns such as the adversary nature of judicial proceedings and the inability of judges to make treatment decisions. Furthermore, the latter exception only postpones the involvement of the judiciary. The "immediate, substantial, and irreversible deterioration" exception only provides for interim treatment without court approval.¹⁶¹ If the treating doctors feel that the treatment should continue, and the patient refuses, the doctors must still seek an adjudication of incompetence and then a substituted treatment decision by the judge if the patient is found to be

Right to Refuse Treatment?, in REFUSING TREATMENT, *supra* note 2, at 88. See also Mills & Gutheil, *Legal Approaches to Treating the Treatment—Refusing Patient*, in REFUSING TREATMENT, *supra* note 2, at 105 (citing Applebaum & Gutheil, *The Boston State Case; "Involuntary Mind Control," The Constitution, and The "Right to Rot,"* 376 AM. J. PSYCHIATRY 720-27 (1980)).

156. Rehlman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233, 234 (1978). *Contra* Brant, *Last Rights: An Analysis of Refusal and Withholding Treatment Cases*, 46 MO. L. REV. 337, 361 (1981) (author argued that involvement of the judiciary in decisions to withhold treatment reflects a recognition that difficult decisions involving conflicting rights should be made by judges).

157. Rehlman, *supra* note 156, at 234.

158. Note, *supra* note 29, at 417. See *Parham v. J.R.*, 442 U.S. 584, 610 (1979).

159. *Rogers*, 390 Mass. at 510, 458 N.E.2d at 321. See *infra* notes 119-21 and accompanying text.

160. *Rogers*, 390 Mass. at 511, 458 N.E.2d at 322. See *infra* notes 119-21 and accompanying text.

161. *Rogers*, 390 Mass. at 512, 458 N.E.2d at 322. See *infra* notes 130-33 and accompanying text.

incompetent.¹⁶²

If granting the right to refuse treatment to involuntarily committed patients had little impact on state hospitals or upon patient treatment, then the state procedural guidelines would most likely be adequate. Physicians argue, however, that the impact will be devastating given that research indicates that more than half of all institutionalized patients are incompetent to make treatment decisions.¹⁶³ If this be so,¹⁶⁴ treatment will become a nightmarish procedural routine requiring constant judicial involvement.

V. CONCLUSION

The supreme judicial court's decision in *Rogers* is significant in that it extended the right to involuntarily committed mental patients in Massachusetts to refuse antipsychotic drug treatment. Furthermore, the opinion provides clear guidance to disability law advocates concerning the substantive rights of and procedural protections for mental health patients under state law. More importantly, however, the decision indicates the need for a legislative re-evaluation of the statutory law governing incompetency proceedings; specifically, whether the existing procedures provide the most practical and protective method for making treatment decisions on behalf of those involuntarily committed patients who refuse treatment. This re-evaluation is decidedly not the job of the courts. Rather, as Judge Tauro stated when this case was before the District Court in Massachusetts "if the statutory scheme is burdensome, redress and relief should be sought from the legislature."¹⁶⁵ Re-evaluation is long past due.

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162. *Rogers*, 390 Mass. at 512, 458 N.E.2d at 322.

163. *See supra* note 5.

164. A great deal of controversy exists concerning the accuracy of such research. Furthermore, it is still too early to measure the impact on state hospitals as a result of the *Rogers* decision. However, the Department of Mental Health estimates that as a result of the *Rogers* decision that approximately 1000 cases may need to be brought to court from the mental retardation facilities and at least an equally large number from mental health facilities. Memo from Richard Ames, General Counsel for the Department of Mental Health (Dec. 16, 1983).

165. *Okin v. Rogers*, 478 F. Supp. at 1363.